pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Grace Packer

Date of Birth: 08/14/2001
Date of Death: 07/09/2016
Date of Report to ChildLine: 01/09/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Montgomery County Children and Youth
Burke County (North Carolina) Department of Social Services

REPORT FINALIZED ON:
02/08/2018

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through the Office of Children, Youth and Families (OCYF), must conduct a review and provide a written report of all cases of suspected child abuse that result in a fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Bucks County and Montgomery County have convened a joint review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 02/06/2017 and a follow-up meeting was held on 04/21/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Grace Packer	Victim Child	08/14/2001
[redacted]	Biological Sibling	[redacted]/2004
	[redacted] Mother	[redacted]/1975
	[redacted] Mother's Paramour/Household Member	[redacted]/1972
[redacted]	Household Member	[redacted]/1978
*[redacted]	[redacted] Father	[redacted]/1976
*[redacted]	Biological Father	[redacted]/1977
*[redacted]	Biological Mother	[redacted]/1981
*[redacted]	Biological Sibling	[redacted]/1998

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

For this review, the Southeast Regional Office (SERO) reviewed available case records and provider documents found in county children and youth case files from Lehigh, Montgomery and Bucks counties for Grace, [redacted] and family to complete the fatality investigation and prior case history. Provider documents reviewed in the county children and youth case files are from the Impact Project foster care agency; Burke County, NC child welfare agency; [redacted]

[redacted] and [redacted] Interviews were completed with the social worker, supervisor and administrator from Bucks County Children and Youth Social Services Agency (Bucks County CYS) who are providing services for the [redacted] presently. Continued contact was made with Berks, Delaware and Montgomery counties in order to gather information in relation to the family's history. Contact was also made with the Montgomery County Detectives, Bucks County Detectives and Abington police, who are the law enforcement agencies investigating the child fatality. In addition, contact was also made with the Federal Bureau of Investigation (FBI) for assistance in assessing the safety of prior foster children in the [redacted] home.

Information was gathered at the 02/06/2017 county review team meeting from the following participants in attendance: Berks, Lehigh, Northampton, Bucks, Delaware and Montgomery counties and The Impact Project, Pinebrook and Valley Youth House provider agencies. SERO and the Northeast Regional Office (NERO) attended the county Act 33 review team meeting on 02/06/2017. SERO also attended the follow-up Act 33 meeting held on 04/21/2017.

In addition, a review of current case practice at The Impact Project, the [redacted] was completed jointly by SERO and NERO. Pennsylvania's statewide database was searched for all previous referrals concerning Grace, [redacted] biological family and [redacted] family.

Summary of circumstances prior to Incident:

In July 2000, Grace's [redacted] became certified [redacted] through The Impact Project, the [redacted] agency for which the [redacted] mother was employed at the time.

On 02/20/2002 Montgomery County Children and Youth (MCCY) received a report due to housing conditions, criminal and drug activity for Grace's [redacted] family. MCCY assessed the family and accepted the family for services and obtained custody of Grace and an [redacted] on 02/22/2002. They were placed in [redacted] at that time. Grace's [redacted] family subsequently obtained new housing and the children were returned to the custody of their parents on 03/14/2002. MCCY continued to implement in-home services through The Lincoln Center. According to the county, the services provided included [redacted] case management, [redacted] and ongoing monitoring of the family situation.

On 01/03/2003 MCCY confirmed that the family moved to Berks County. At that time, MCCY records reflect, and Pennsylvania's statewide database confirms, that the agency had [redacted] Grace's [redacted] for [redacted] and MCCY recommended that the children were to have no contact with her; however, the family maintained residence with the [redacted] in Berks County. MCCY closed their case with the family on this date as the family had moved to Berks County and a referral was made to Berks County Children and Youth (Berks CCY).

On 01/06/2003 Berks CCY accepted the family for services. The family received a variety of services through the agency and community including parenting education, [redacted] and hospice services for the [redacted] who continued to reside in the home, even though the children were to have no contact with her. There were concerns for the [redacted] ability to appropriately care for the children.

On 02/27/2004 Berks CCY [redacted] following a non-offender assessment completed by [redacted] to determine whether the parents could protect the children. The assessment concluded that the [redacted] parents were unable to provide appropriate protection from abuse by family members. The children resided in different [redacted] during the next few months due to the [redacted] behaviors and adjustment in the homes. The [redacted] mother was pregnant with her third child at this time. This child was born on 5/11/2004 and [redacted] was assumed by Berks CCY the next day and [redacted] due to the family history and assessment of inability to provide protection for their children.

On 10/05/2004, all [redacted] which would eventually become [redacted] for Grace and her [redacted]

During the summer of 2005, Grace (then age 4) received two separate [redacted] evaluations as the [redacted] reported to Berks CCY that Grace had been displaying [redacted] behavior. The evaluation identified concerns that Grace may have been molested however it was unknown when this happened or who may have abused her. Recommendations from these evaluations were that Grace receive [redacted] and not be left unsupervised around other children, especially her [redacted] due to prior sexual behavior between [redacted] Through the current review of the case history, it could not be determined if changes to the level of supervision of [redacted] changed as a result of that recommendation but it is noted that Grace became involved in [redacted]

Berks CCY filed a [redacted] on 08/04/2005 which triggered referrals for an [redacted] to be completed on the [redacted] This profile was completed by Pinebrook Family Services with the recommendation that the [redacted] be the identified [redacted] resource for [redacted]

From 01/30/2006-02/20/2006 the [redacted] was removed from the home and placed in respite after it was determined Grace was sexually assaulted by [redacted] After the [redacted] was returned to the home, the family installed alarms on the doors to monitor the movement of the children. The [redacted] remained in the home until 05/22/2006 when she was [redacted] for aggressive behaviors. She returned on 06/06/2006, but was [redacted] again 07/10/2006. She did not return to this home as she expressed concerns regarding her treatment in this home. (Note – [redacted] could not be identified through this review due to record expunction).

During the subsequent months, Grace's [redacted] expressed concerns about the parenting ability of the [redacted] and Berks CCY halted the [redacted] of Grace [redacted] by this family until additional support and monitoring could occur. Following a period of months in which there were no verified reports of concerns, Berks CCY made the decision to proceed with [redacted] and on 03/16/2007 Grace [redacted] After [redacted] occurred, the family continued to be [redacted] for The Impact Project.

On 05/30/2007 the NERO received a [redacted] sexual abuse of Grace's [redacted] which occurred during the time the [redacted] resided in [redacted] Lehigh County Children and Youth (LCCY) assisted in a courtesy interview of the child. The report was unable to be [redacted] and details of the investigation and report circumstances were [redacted]

On 05/02/2008 the NERO received another [redacted] alleging inappropriate physical discipline of Grace by the [redacted] The report was unable [redacted] and details of the [redacted] circumstances were [redacted]

On 11/05/2008 LCCY received a [redacted] that a [redacted] not Grace [redacted] was not provided with appropriate medical care and follow up for [redacted] LCCY responded by interviewing the [redacted] and Grace's [redacted] and verifying that the child did indeed have the medication as needed. [redacted]

On 06/16/2009, Grace's [redacted] became [redacted] of another [redacted] who had been placed into their care through Delaware County Children and Youth (DCCY). This subsidy ended 12/11/2009 when that child turned eighteen years of age.

On 01/15/2010 the NERO received a report for sexual abuse of the [redacted] The Impact Project immediately [redacted] and all [redacted] children and the victim child were removed. Grace was informally moved to her [redacted] home and her [redacted] was moved informally with the [redacted] as part of LCCY's initiated safety plan that was presented to and accepted by NERO during the [redacted] by the regional office. The [redacted] who was employed with Northampton County Children and Youth (NCCY) at the time, was terminated from her job. On 03/04/2010 the [redacted] was [redacted] and the [redacted] was [redacted] as she was aware of the abuse occurring but failed to intervene to protect the child.

Grace and her [redacted] remained in the care of their [redacted] informally, but the [redacted] were permitted supervised visits with the children. The [redacted] supervised the contacts. The living arrangements for Grace and her [redacted] were established as part of a

Safety Plan initiated by LCCY. There was no court involvement in these arrangements. LCCY maintained an open case on Grace and [redacted] however, it is noted that the [redacted] were not in agreement with services and would not sign the Family Service Plan. Both [redacted] did, however, have [redacted] evaluations completed by [redacted] The [redacted] occurred on 03/26/2010 and 06/03/2010. The [redacted] occurred on 3/26/2010.

[redacted]

On 06/08/2010 LCCY received a [redacted] for sexual abuse of Grace. The [redacted] was listed as the alleged perpetrator. The abusive acts occurred during the time that Grace and the [redacted] resided in the [redacted] home and were prior to the report that was filed on 01/15/2010 regarding the [redacted] child. The [redacted] was not a part of the referral nor did the investigation reveal any involvement of the [redacted] in this abuse. The county amended the safety plan and the [redacted] was no longer permitted any contact with Grace or [redacted]

LCCY subsequently received the evaluation reports on the [redacted] The evaluations occurred prior to Grace's disclosure of abuse however the findings of the evaluations were received after the disclosure. Even though the evaluator was unaware of Grace's victimization, the evaluator recommended that the [redacted] have no contact with Grace or any child and that he attend [redacted] The evaluator found that the [redacted] did not pose a risk of direct harm to the children as long as the [redacted] was not involved and believed that she could serve as a caretaker for the children. The evaluator noted that the [redacted] admitted to a sexual relationship with the [redacted] child; however, the evaluator did not identify this as an abusive matter as the youth was over the age of 18. The evaluation failed to speak to the parent/child relationship within the context of this sexual activity.

Grace was [redacted] from 06/29/2010-07/03/2010 and again from 07/12/2010-07/22/2010 for behavioral concerns and [redacted] struggled to provide the care that she needed. She was transferred to [redacted], from 07/23/2010-08/19/2010. These [redacted] were through [redacted] and not ordered through court or LCCY. During this time period, the [redacted] began non-offending parent services and [redacted] with Confront as recommended by the forensic evaluator.

On 07/19/2010 the [redacted] moved out of the family home and the [redacted] was returned to [redacted] care. Grace returned to the [redacted] care on 08/19/2010 upon discharge from the [redacted] with [redacted] Services provided through Valley Youth House. There was to be no contact for either child

with the [redacted] The family remained open for services with LCCY who maintained an ongoing case and involvement with the family.

On 07/29/2010 LCCY [redacted] the sexual abuse of Grace [redacted] after his plea of guilty and subsequent sentencing for the crimes. He was arrested on 09/23/2010 and charged with the crime of Indecent Assault of a Person less than thirteen years pertaining to his abuse of Grace. He was additionally charged for the sexual abuse of the SPLC child with Statutory Sexual Assault, Involuntary Deviate Sexual Intercourse of a Person less than sixteen years and Corruption of Minors. The [redacted] entered a guilty plea for Indecent Assault and Statutory Sexual Assault charges and was sentenced six months to three years at a State Correctional Institution. He was declared by the court as a sexually violent predator under Megan's Law.

The family continued to receive Family Based Services through Valley Youth House over the next few years, however, the [redacted] became uncooperative with the county and would not schedule home visits with the county worker. Despite this, safety assessments based on contacts and interviews with the children conducted during this time period did not identify any safety threats.

On 04/20/2012 the county children and youth agency learned that Grace and her [redacted] had engaged in sexual interaction with one another with Grace [redacted] Services were already in place and the incidents were being addressed with [redacted] No additional action was taken by the county in response to the report. The county children and youth agency closed the family for services in September 2012, however, the family was still receiving support from the [redacted]

Over the next few years, Grace was hospitalized several times [redacted] and received [redacted] treatment at [redacted] including [redacted] through the [redacted] At some point, the [redacted] met her present paramour. The family eventually relocated from Lehigh County to Montgomery County on 08/15/2013. Grace was discharged from [redacted] on 12/13/2013 and [redacted] Services through Warwick were provided through the [redacted]

On 06/26/2014 MCCY received a [redacted] and Law Enforcement Officials received the same report, that Grace was sexually inappropriate with [redacted]. MCCY did not accept the report for investigation, stating no abuse or neglect issues were noted. Law enforcement contacted the [redacted] who informed them that this was previously investigated and that Grace was currently in [redacted] and may not be returning to the home. There would be no further investigation into the allegation.

Grace was approved for discharge from [redacted] on 01/18/2015, however, the [redacted] reported she was not willing to have the child reside with her and the [redacted] made private arrangements with family. Grace began residing in Burke County, North Carolina with [redacted]

On 11/20/2015 Burke County (NC) Department of Social Services (BCDSS) received a report requesting assistance in services and placement for Grace by her caregivers in that state. The caregivers were informed that the transfer of custody documents they had for Grace were not valid and the child was required to return to the care of her [redacted] in Pennsylvania. She returned on 11/23/2015. Two days later, BCDSS contacted MCCY requesting the county assess the [redacted] home for safety as the child has returned to her [redacted] care. MCCY did not agree to support this request without present concerns for abuse/maltreatment and referred BCDSS to the local police department to assist with a welfare check of the child. The police department notified BCDSS the child appeared okay and BCDSS closed their case. Grace continued to receive an array of [redacted] services including [redacted]

Almost a year later, on 11/12/2016, Bucks County CYS received a referral when Grace's [redacted] was arrested for obstruction and endangerment for her lack of cooperation with the police investigation in the disappearance of Grace. The child was reported to the police as a runaway from the home in Montgomery County in July 2016, prior to the family relocating in Bucks County, and her dismembered body was discovered on 10/31/2016 in a remote area of Luzerne County. Bucks County CYS immediately implemented services for Grace's younger sibling and placed him in [redacted] with the [redacted] Prior to [redacted] Bucks County assessed the [redacted] ability to protect the child which included a determination of their belief in the culpability of [redacted] in sexually abusing Grace and the [redacted] child. This assessment determined that the [redacted] who had initially struggled with believing [redacted] had committed acts against these girls, were now in a position in which to protect their [redacted] and be a [redacted] for him.

<u>Circumstances of Child Fatality and Related Case Activity:</u>

On 01/09/2017 Bucks County CYS received a [redacted] alleging a fourteen-year-old female child, Grace, was raped and murdered by her [redacted] and the [redacted] Together they physically and sexually assaulted the child, plotted her murder and dismembered and disposed of Grace's body. The [redacted] confessed to police after a failed suicide attempt on 01/08/2017. The [redacted] were incarcerated without bail for the incident which took place from 07/08/2016-07/09/2016. After Grace's death on 07/09/2016, her body was stored in the home in Bucks County until it was dismembered and disposed of sometime in October 2016. The [redacted] were charged with multiple offenses including criminal homicide, involuntary deviate sexual intercourse, kidnapping, rape, unlawful restraint, endangering the welfare of a child, abuse of a corpse, assault, possession of an instrument of crime, tampering or fabricating with

evidence and conspiracy. Their criminal trial is scheduled to occur in 2018. Prosecutors are seeking the death penalty for both.

On 02/16/2017, Bucks County CYS submitted a [redacted] due to the ongoing criminal proceedings. The investigating social worker was not able to interview anyone with regards to the report due to the court issued order and ongoing criminal investigation.

The county continues to provide [redacted] in the care of the [redacted] who have continued to provide him with the care and support needed. The [redacted] was not present in the home at the time of the rape and murder and was visiting with the [redacted] at the time. He does not have contact with the [redacted] per criminal court order. The [redacted] was briefly paroled from prison but has since been returned to prison for violation of his condition of release. As deemed a sexually violent predator under Megan's Law, he was in violation when he viewed pornography and had contact with minors, including suspicion he had unsupervised contact with his [redacted] There is no finding that contact with his [redacted] occurred. There is no contact while in prison.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:

The information in this section comes directly from the County Review Team report:

- Strengths in compliance with statutes, regulations and services to children and families;

It appears that all child welfare services were provided in compliance with statutes and regulations. Collaboration occurred in several instances between law enforcement, child welfare, and other community services. On at least one occasion, Grace was interviewed at a child advocacy center with the Multidisciplinary Investigative team present. The case was also reviewed at internal child welfare critical case meetings. The [redacted] family was offered the opportunity to participate in Family Team meetings on several occasions but it appears that they declined. Law Enforcement and child welfare agencies collaborated during child abuse and criminal investigations.

During the three years that this case was open for services in Lehigh County, the same caseworker was assigned to this family allowing for continuity of service. This caseworker was very active and involved with this family as was seen by the extensive case documentation. During the time the case was open in Berks and Lehigh Counties, many community, social service, and other professional services were provided to this family. Additionally many child-serving systems such as school, [redacted] and health care were actively involved during various times in this case. Grace received school evaluations and several Individual

Educational Plans (IEP) were developed to meet her special needs. Grace also received [redacted] evaluations and was receiving [redacted] services, including [redacted] on several occasions. Attempts were made by Berks County prior to [redacted] to assure that Grace would continue to have contact with an [redacted] who was [redacted] in the same home.

- Deficiencies in compliance with statutes, regulations and services to children and families;

During the time of the child sexual abuse investigations into [redacted] Grace was placed on an informal basis with her [redacted] continued to have access to Grace at [redacted] home although it is unclear if any of those contacts were unsupervised. While at [redacted] home, Grace revealed sexual abuse by [redacted] who later admitted to his sexual contact with Grace. [redacted] did not believe the allegations by Grace, and it was noted that they exhibited openly hostile and angry behavior to Grace when she was brought to the Child Advocacy Center for an interview. Grace was maintained in this home by Lehigh County until her return to [redacted] home.

The sexual abuse allegations [redacted] yet Grace and [redacted] were returned to the care of [redacted] because [redacted] was no longer in the home. The nature of [redacted] involvement in the sexual abuse of another [redacted] child, per her own admission and documented in the [redacted] evaluation, did not result in the removal of Grace from her care and did not prevent Grace from returning home. Despite the history of sexual abuse, numerous [redacted] sexual abuse reports, and [redacted] admission of active involvement in sexual abuse of a [redacted] child, Grace and [redacted] were returned to [redacted] care. During the sexual abuse investigation, Lehigh County did not consult with their solicitor or seek court jurisdiction.

The evaluations of [redacted] completed by [redacted] has the potential to be flawed due to the Lehigh County policies that limit the information that can be provided for an evaluation. It was reported that Lehigh County could only relay information on the specific allegations involving another [redacted] child and could not relay data on Grace's background or behavior that may have provided more insight into the development of the final recommendations. Lehigh County child welfare and the evaluators reported that the county legal system limits what they are able to provide to evaluators in advance. Additionally, there was not a case conference or team meeting to discuss the findings of the evaluations which may have resulted in further insight into the best next steps for the [redacted]

Even with the limited information provided, the evaluators elicited a confession from

[redacted] of her active participation in the sexual abuse of the [redacted] child that did not result in stronger recommendations regarding the safety of Grace and [redacted] Both the [redacted] evaluators and the County determined it was safe to return these children home despite the seriousness of the history and [redacted] participation in sexual activity with a [redacted] child.

Burke County child welfare did not view the case as an 'abandonment' or a [redacted] when it was brought to their attention by the [redacted] caretakers of Grace who could no longer manage her in their home in North Carolina. Therefore, they located [redacted] and arranged for her to pick up Grace to return to Pennsylvania without any assessment of safety. In fact, they did not feel they had any safety or child welfare concerns at the time [redacted] drove to North Carolina for Grace despite the reports from [redacted] and Grace's admission of feeling unsafe in the [redacted] home. Burke County did not take custody and thus could not utilize the Interstate Compact process to request an assessment of the [redacted] home. After Grace was residing in Pennsylvania, Burke County requested a home check for the sole purpose of 'closing their case as is standard procedure.'

There were multiple [redacted] allegations and investigations involving the [redacted] throughout the years. These investigations were conducted by various county child welfare agencies and the Pennsylvania Office of Children, Youth and Families NERO staff. It was difficult to assess the appropriateness of the outcomes of these investigations as [redacted] material was expunged. The information regarding the many allegations/investigations was found in case records with minimal information due to expungement requirements. It appeared that one report documented a physical injury to Grace based on her report of pain and inability to sit. However, that report [redacted] so no other information could be located. With multiple allegations/investigations over several years, it would seem that this case should have been thoroughly assessed for the safety of Grace and [redacted] and maintained as an open case for a longer period of time. Lastly, as many of the investigations were [redacted] new investigations did not have the history of previous allegations or the insight from previous investigations. It appeared that ChildLine did not provide the history of all prior reports when a new allegation was reported.

The [redacted] were approved as [redacted] for adolescents at Impact Project, yet [redacted] and [redacted] were placed [redacted] in the home. At that time, [redacted] also worked as a caseworker for Impact. The [redacted] were designated as a [redacted] despite a lack of any evidence that they received special training. Impact's caseworker reported that the agency did not require any special skills or training to be [redacted] but hoped that [redacted] would voluntarily access supplemental training. It appears to be a conflict for [redacted] to be approved as [redacted] at an agency for which she was employed.

Pinebrook Services completed the [redacted] via [redacted] services. The references obtained were from the [redacted] parents, a friend, and an Impact Project caseworker. The caseworker noted that she felt 'flattered' to be asked to be a reference for the family. No objective, independent references were sought. [redacted] parents noted that the [redacted] would not do well with a 'strong-willed or defiant child.' Grace's behavior issues tend to fall into that category, and it was curious why [redacted] was deemed as appropriate for her.

The Berks County caseworker stated that the county agency did not make home visits to the [redacted]-only the Impact caseworker visited the [redacted] home.

Repeatedly, it was noted that Grace was receiving [redacted] services, yet it seemed that much of it was not focused on the key issues in this child's life. The focus did not seem to be on her [redacted] behavior, her sense of abandonment by her [redacted] when she was sent to North Carolina, or the failure of her [redacted] to protect her from sexual abuse by her [redacted] In one case it was noted that her [redacted] was an intern rather than a seasoned [redacted] with experience in such severe sexual abuse. While she [redacted] at Warwick House, there appeared to be much time spent with [redacted] who was misrepresenting her own 'traumatic' past rather than time spent with Grace. Every county child welfare agency noted the lack of resources for children who have been abused or exhibit serious sexually reactive behaviors. It was also noted that more collaboration should occur between residential treatment facilities/mental health hospitals and the child welfare system prior to the discharge of a child.

Finally, after a thorough review of all case history into this girl's life was conducted the Fatality Team identified many red flags. Due to the overburdened child welfare system, this type of thorough review would be impossible for all complex cases. A review such as this connects the dots and helps to paint a clear picture of the ways that Grace and her siblings may have been better served by all systems involved in their life.

It is important to note that the child welfare system as it stands today is overwhelmed. All recommendations stated in this report need to be accompanied with adequate resources and staffing in order to implement the necessary changes to ensure the safety of children, like Grace Packer, and to maintain best practice standards.

Department Review of County Internal Report:

The County Internal Report was issued jointly by Bucks County and Montgomery County. The Department received the draft report provided by the counties dated 05/08/2017. The final report was received on 06/14/2017. The Department provided a preliminary response to both counties on 08/07/2017.

The Department has reviewed the county findings of the report and cannot support the finding that specifically addresses prior investigations in the [redacted] home. The report states: "It was difficult to assess the appropriateness of the outcomes of these investigations as all [redacted] The information regarding the many allegations/investigations was found in case records with minimal information due to expungement requirements. However, with the little that was available, it was apparent that much was suspected to be going on in this home and in fact, at least on one occasion it appeared that a report was [redacted] The county review accurately identifies that multiple reports were investigated in the [redacted] by county and state investigators and these reports were expunged in accordance with statute. The Department cannot agree with the county report's statement that based on the minimal information there was [redacted] when the records contained no investigatory interviews, medical evidence, photographs or [redacted] given at the time of the investigation in 2008. The Department cannot support making a statement of definitive finding without access to investigative facts.

The following section contains the recommendations for changes at the state and local level toward reducing the likelihood of future fatalities and near fatalities, monitoring and inspecting of county agencies and collaboration of community agencies to prevent child abuse. The recommendations as identified and categorized are directly from the County Review Team report. Following each recommendation is the Department's response.

RECOMMENDATIONS FOR CHILD WELFARE PRACTICE

1) Staff should be trained on the importance of viewing the entire case history when assessing risk and safety, not just a "point in time" as reflected by one report.

   Department Response: The Department agrees that history is a critical component when assessing risk and safety. The Child Welfare Resource Center's Charting the Course training modules on Risk Assessment and the Safety Assessment and Management Process address looking beyond the "point in time" when assessing risk (the Risk Assessment Tool specifically speaks to prior history) and safety (helps in the identification of protective factors).

2) Case documentation should be clear and specific, including but not limited to, documenting who was seen for each visit.

   Department Response: The Department agrees case documentation should be clear and specific. DHS Regulations specific to the Administration of County Children and Youth Social Service Agencies (Title 55: PA Code: Chapter 3130) addresses documentation. Chapter 3130.43 (b)(5)

specifically speaks to what is required in the family case record related to record of activity. A record of service activity, including the following:

(i) The dates of the contact with family members.
(ii) The parties involved in the contact.
(iii) The action taken.
(iv) The results of the actions.

In addition, the structured case notes format which encompasses the regulatory requirements also frames the content of the contact for continual assessment of safety. During the Safety Assessment and Management Process module of training, the critical need for effective documentation is stressed. Specifically, a handout in the training states:

> "Proficient documentation is essential to support a supervisor or colleague's ability to assure a child's safety, well-being, and permanence, or testify in court when the author of the case note is not available. Every case note should be written as if it might be read by an attorney, judge, or state or federal reviewer because such a review could occur. Competent documentation must be objective, accurate, clear, descriptive, relevant, and concise and review the definition of each principal."

3) Child welfare agencies must have consistent case documentation and organization and not close a case until all documentation/paperwork is complete.

Department Response: The Department agrees that case closure should not occur until all required documentation has been completed by the caseworker and approved by the supervisor. Closing dictation, a closing risk assessment and safety assessment are required. In addition, cases should not be closed until final progress reports are received from service providers and reviewed by the worker and supervisor in support of the agency's case closure determination.

4) County child welfare agencies must provide full case information when referring a case to another county child welfare agency and receiving agency must review all information prior to deciding whether or not to accept a case for assessment.

Department Response: The Department agrees and the sharing of information between counties is addressed in the Child Protective Services Law (CPSL) Regulation, Chapter 3490.401 related to Intercounty Transfer of Cases. In addition, the statewide database currently provides information related to reports of Child and General Protective Services. Future phases of Child Welfare Information Solution (CWIS) will capture information beyond the intake investigation for those cases receiving ongoing services from the county children and youth agency. This statewide database will enable the access of information from one county to another. However, the Department

one county to another. However, the Department further stresses that the electronic sharing of information alone is not sufficient and there must be an ongoing conversation between counties that previously served the family in order to best protect and serve the children and family.

5) It is recommended that a protocol be established to assure that all law enforcement only reports (LEO's) received by Children & Youth agencies are reviewed by a supervisor to determine whether there are child welfare concerns embedded in the report.

   Department Response: Many county agencies have a specific unit whose sole purpose is to receive and assess referrals for service. Counties who do not have designated units will have staff assigned for a particular timeframe to receive and screen new referrals. The Department agrees that the case acceptance or screen out decisions made by the intake screener be reviewed by a Supervisor. Counties are identified as the secondary recipient on LEO referrals. If the county review of the report notes possible child welfare issues, the county should have the referral registered as a GPS referral.

6) All placements should be determined by the needs of the child. In some cases, a child is best served long term in a community or residential setting. County child welfare agencies should not be penalized for pursuing a more restrictive placement option. Had Grace received the appropriate services and [redacted] early on, she may not have needed more restrictive settings. However, as she aged, it appeared she could have benefited from a structured residential setting.

   Department Response: The Department agrees that services should be individualized and determined by the needs of the child, whether it is an in-home service or a placement setting. The Juvenile Act requires at a permanency review hearing that the court determine if the placement setting is best suited for the safety, protection, physical, mental and moral welfare of the child. Counties must seek the least restrictive placement to meet the needs of the child. While there are efforts statewide to decrease the use of congregate care, the Department does not penalize the county for pursuing a more restrictive placement for a child if the child cannot be safely maintained in a less restrictive setting.

7) For cases involving foster care, caseworkers must meet individually with the child or children at a minimum of once every 30 days. If it is a two-parent foster home, a caseworker must meet with both parents. In addition, if the 30-day visits are made by a contracted provider agency, the county caseworker must visit the child(ren) and foster parents at a minimum of every 90 days. The definition of quality of contacts should be enforced as defined in Bulletin 3490-08-05, entitled Frequency and Tracking of Caseworker Visits in Federally Defined Foster Care.

Department Response: Chapter 3490.235, Child Protective Services Regulations currently require:

> (g) When a case has been accepted for services, the county agency shall monitor the safety of the child and assure that contacts are made with the child, parents and service providers. The contacts may occur either directly by a county agency worker or through purchase of service, by phone or in person but face-to-face contacts with the parent and the child shall occur as often as necessary for the protection of the child but at least as often as:
>
> (1) Once a week until the case is no longer designated as high risk by the county agency, if the child remains in or returns to the home in which the need for general protective services was established and the county agency has determined a high level of risk exists for the case.
>
> (2) Once a month for 6 months or case closure when the child is either:
>
> (i) Placed out of the home or setting in which the need for general protective services was established.
>
> (ii) No longer determined to be at a high risk by the county agency.

In addition, within the same regulatory chapter cite, authority is granted to the agency to perform case management functions rather than direct case monitoring and in doing so, the requirement for face-to-face contact is deferred to the provider except that (c) the county agency shall monitor the provision of services and evaluate the effectiveness of the services provided under the family service plan under § 3130.63 (relating to review of family service plans). The county agency worker shall visit the family in performing the case management responsibilities as required by § 3130.63 as often as necessary for management of the service provision at least every 180-calendar days.

The Department agrees that all parties and household members should be seen regardless if the contact is being conducted by a qualified caseworker or a county agency staff. In addition, the Department concurs that county agency contact more frequently than statutorily required would be best practice.

8) Case conference/teaming meetings are necessary among all team members following the completion of any evaluations (e.g. psychological, psychosexual, etc.) completed on any family members to assure an understanding of findings and a clear path forward.

Department Response: Pennsylvania's Child Welfare Practice Model identifies Teaming as a key principle and practice. The Department agrees that the use of a teaming approach at critical case decision points, such as the review of key evaluations by the team toward defining a clear path for the case, would be best practice.

9) When professional evaluations are obtained, counties need to clearly document their response to recommendations. Evaluators should receive all family history information in order to adequately assess the impact of findings on child(ren) and family system.

Department Response: The Department concurs with this recommendation and this is existing expected practice. Evaluators should be provided with information at the point of the referral for evaluation so as to inform the process. When the evaluation has been received by the agency, it should be reviewed at a minimum by the caseworker and the supervisor to help inform the next steps in the case. This should be reflected in case notes and supervisory notes.

RECOMMENDATIONS FOR CPS/GPS INVESTIGATION PROCESS

1) CPS and GPS reports on foster homes must be investigated by regional OCYF staff.

Department Response: The CPSL specifically identifies in Section § 6362 that the county agency is the sole civil agency responsible for receiving and investigation reports of child abuse made pursuant to the law. Subsection (b) allows for the Department to assume county responsibility in investigations of child protective services reports when the suspected abuse has been committed by the county agency or its agents or employees. The CPSL also specifies a county agency as the sole civil agency responsible for receiving and assessing reports of children in need of general protective services (§6375 (d)) however there is no consideration in statute that authorizes the Department to assess GPS referrals.

The Department is made aware of GPS referrals in a foster home. The notification occurs at the time of the report, or in a subsequent notification, when the subject family of the referral is identified as a foster home. In those cases, the Department's regional office receives the report in a secondary nature. If the report identifies practice concerns, such as the use of discipline or inappropriate levels of supervision, the regional office will review the assessment and findings of the county agency in response to the GPS referral. The regional office will follow up with the foster care agency based on the county's findings and if regulatory violations are identified, the foster care agency will be required to submit a corrective action plan to address the violations.

2) OCYF Regional Office CPS investigations shall be conducted in the same manner as county CPS investigations, including but not limited to, reviewing the history of allegations and criminal history, interviewing all potential collateral contacts, and conducting developmentally appropriate interviews of all children in the home.

Department Response: The Department agrees. CPS investigations should be comprehensive and investigated in the same manner regardless of whether the investigator is a county staff or regional office staff. In addition, when abuse investigations are conducted by regional offices, the investigator should utilize the Child Advocacy Centers (CAC) to assist in the investigation, and also be an active part of the MDIT team for that child. The regional office staff should provide information directly to evaluators and treatment providers related to the investigation and share information gathered that would inform assessments and treatment of the child and family.

3) Abuse investigations in foster and adoptive homes should include interviews of all children currently living in the home and children who were living in the home in the past five years. If an interview is not being conducted, documentation is required as to why the interview did not take place, for example, if the children had been previously interviewed.

Department Response: The Department agrees that investigation thoroughness may entail the interviews of former children placed in a home or facility. Investigations in foster and adoptive homes should include all children currently residing in the home being interviewed. As the investigation proceeds, any information that identifies previous foster children as potential victims or collateral witnesses would necessitate interviewing those children. In circumstances where a foster or adoptive parent has been found to victimize multiple children, reaching out to all prior placements for interviews as suggested in this recommendation would be appropriate.

4) To allow for quality CPS/GPS investigations by the Region, establish a specialized investigation unit that focuses solely on the investigation of licensed homes/facilities.

Department Response: The OCYF Regional Offices perform a variety of functions, one of which is acting as the child protective services investigator in lieu of the county agency. Through Continuous Quality Improvement efforts that are underway at OCYF, the workload and structure is an area that is under review and analysis.

5) Situations where there are allegations of sexual misconduct between siblings, and the offender is not of age designated by CPS law, should be addressed by MDITs or CACs (as available) as required for CPS cases under CPSL.

Department Response: The Department agrees that reports of sexual contact between siblings that do not meet the definition of suspected child abuse per the CPSL, should be referred to law enforcement for review and investigation. CACs and the MDIT are appropriate venues for the assessment of the allegations. Per the CPSL Section 6334.1 (3) - If the suspected child abuse is alleged to have been committed by a person who is not a perpetrator and the behavior constituting the suspected child abuse may

include a violation of a criminal offense, law enforcement officials where the suspected child abuse is alleged to have occurred shall be solely responsible for investigating the allegation. In these circumstances, ChildLine sends the report to the District Attorney as the LEO entity for the county.

6) New CPS/GPS referrals on open child welfare cases should be completed by an Intake caseworker separately but collaboratively with the ongoing caseworker and the MDIT as appropriate.

   Department Response: The Department agrees and recommends the MDIT be involved as appropriate for CPS reports. There are currently county children and youth agencies that have a structure in place that any new referral on an existing open case is handled through the Intake Department. In other counties, it is only CPS investigations that are assigned to Intake and new GPS referrals may be the responsibility of the ongoing caseworker to assess rather than handled through Intake. County staff size can impact the ability of a county to have its Intake staff become the investigators for all CPS/GPS referrals on open cases. This is particularly the case for smaller counties. Further assessment and analysis of the impact of the review team's recommendation specific to the intake function would need to occur before the Department can respond.

RECOMMENDATIONS FOR FOSTER CARE/ADOPTION PRACTICE

1) Ensure compliance with regulations regarding maintaining of adoption case records.

   Department response: The Department agrees and conducts annual inspections on county children and youth agencies as well as private licensed adoption agencies to monitor compliance with records retention.

2) Procedure for obtaining appropriate references for adoption applicants should be reviewed by SWAN [redacted]
   Independent, non-relative references must be required. Observation/comments by family members and assigned or previous caseworkers could be solicited but should be in addition to objective references.

   Department response: Title 55 PA Code: Chapter 3350 – Adoption Services does not require references but does state under 3350.12 (b) that when references are used, they shall come from the persons who have observed the applicants in situations that may indicate their capacity for parenthood. Not all adoption agencies are SWAN affiliates, but all agencies are subject to regulatory compliance. The Department agrees that references from a variety of individuals would be best practice.

3) Consideration should be given to “fresh eyes” being provided when foster parents are being re-evaluated on an annual basis.

Department response: The Department recognizes the intent behind this recommendation as an opportunity to gather new information or observe things that a person with familiarity might overlook; however, knowledge of the family provides history and additional context that within a re-evaluation would be critical information to assess. This is much like the licensing practice of the Department in having a consistent staff person assigned to an entity but also having other staff assist in the annual recertification.

4) Provider agency foster care caseworker must inform/communicate with all county agencies placing children in assigned foster homes, monitor progress of all placements, and serve as “gatekeeper” for that home.

Department response: The Department agrees that the line of communication between the provider agency and the county agency placing a child in the home is critical. In cases where there may be children from multiple counties placed together in one home, the monitoring, communication and ongoing sharing of information becomes even more essential. The regional offices can assist in facilitating communication among counties and the foster care agency.

5) The caseworker of every child being placed must be provided information on the composition of that foster home, and details of the children placed in that home, to ensure an appropriate match. The county with custody must be made aware of every complaint, referral, or report regarding foster parents or household members including any other foster children in the home.

Department response: The Department agrees and this is the current expected practice.

6) Statewide standards are needed for Treatment Foster Care including qualifications, “treatment” responsibilities, and training requirements of caregivers.

Department response: The Department agrees. Treatment Foster Care is a classification that many entities use but is not truly defined. Foster homes that have a mental health treatment component for the child are licensed as Community Residential Rehabilitation Services (CRRS) Host Homes through the Office of Mental Health and Substance Abuse Services under Chapter 5310. The definition of a Host Home is listed as: A private residence of a family, other than the home of the child’s parents, with whom the CRRS contracts to provide a structured living arrangement for one to three children. While the regulations do not speak directly to the training requirements, the standards of care issues by the Managed Care Organizations identify minimum training requirements as well as ongoing training, for example, Value Behavioral Health requires 40 hours of ongoing

training for the Primary Host Home Parent and 20 hours for the Secondary caregiver. The training hours required under Community Care Behavioral Health are 24 hours and 12 hours respectively.

The Department concurs that treatment standards for levels of Resource Family Care would be best practice with an included focus not just on training hours but the content of required training as well assuring a continuum of training opportunities targeting the populations served that would exceed the minimum annual training hours for foster homes as identified in Chapter 3700.

7) Consideration should be given to whether subsidized adoptions and SPLC arrangements should receive periodic home visits. SWAN aftercare services should be offered where appropriate.

Department response: SWAN after-care services are offered to families if they elect to utilize the services. With regards to periodic home visits for finalized adoptions or legal custodianship being required, unless there is some concern for the safety and well-being of children, this would violate one's right to parent without the interference from the county children and youth agency.

RECOMMENDATIONS FOR CASE RECORDS

1) OCYF needs to create a standardized log form and require every case record to maintain a log stating each referral received, type of referral, disposition, the name of assigned caseworker and supervisor and dates. This log should not be expunged.

Department response: Each county data system has the capacity to identify referrals received on the families including the identification of staff involved. With the onset of the statewide database, there is the capacity to link current referrals to prior CPS referrals for the historical view across counties. Prior GPS referrals beginning with those received on or after 12/31/2014 (the date of the database implementation for GPS referrals) are also linked.

The minimal information contained in the logs would be expunged when the record is expunged under current statutory expungement mandates. The Department acknowledges and supports the current reviews occurring related to proposed changes of expunction laws.

2) Establishing protocols regarding file organization throughout all counties would assist in Act 33 case reviews, particularly when several counties are involved. When materials are requested for an Act 33 review, all case information must be provided in a chronological order, organized and timely.

Department response: Title 55 Chapter 3130.43 speaks to what must be contained in a county case record, whether hard copy or electronic. The Department recognizes the challenge experienced by the county review team in looking at copies of records from multiple counties. The historical records from the case under review were in existence prior to many of the county's electronic case management systems or may have included printed out hard copies from electronic fields. Determinations of case presentation format may be an area that counties could examine in their continuous quality improvement efforts within their Act 33 review process.

RECOMMENDATIONS FOR RESOURCES AND CONTRACTED SERVICES

1) DHS to convene a task force to establish statewide solutions for resource development to meet the unique needs of children in foster care, children who have been sexually abused, and children experiencing trauma and loss, including the critical lack of placement resources for children with complex needs.

   Department response: In 2017, the Administration of Children and Families completed its Child and Family Services Review of the child welfare services in Pennsylvania. One of the findings that will be addressed in the Commonwealth's Program Improvement Plan is around the area of service array. The Pennsylvania (PA) Child Welfare Council, which includes cross system multidisciplinary membership, has chartered a Resources and Cross-System workgroup which is tasked with reviewing the area of services array and resources for our children and families being served.

2) State OCYF must advocate for mental health treatment resources that meet the unique and complex needs of children who have experienced sexual abuse and/or exhibit sexually reactive behavior, and/or have been adopted at a later age. A review of rates offered via Medical Assistance must be conducted. State advocacy of an increased rate structure should occur or supplemental funds should be made available as to not limit the potential therapy/counseling options.

   Additionally, the state should develop resources of specifically trained, licensed, certified, and experienced therapists/counselors who have the skills needed to meet the needs of this population.

   Department response: As previously stated, the Resources and Cross-System workgroup of the PA Child Welfare Council will be reviewing this matter. Any recommendations related to payment structure regarding the services identified will trigger further analysis and collaborative efforts among the funding sources.

3) An enhanced service array in each community is essential and needs to be explored via collaboration between child welfare, behavioral health care, and

other child and family serving systems (i.e. a larger pool of available trained psychologists to complete child or parent evaluations).

Department response: The Department concurs and can be addressed as previously described.

4) All reports from provider or community service agencies need to be reviewed at the contracting county agency for factual consistency. Impact Project [redacted] reports provided to Lehigh County contained many inaccuracies including wrong dates, and this misinformation was then repeated as truth.

Department response: The Department agrees that county agencies must review all subcontractor reports not only for factual consistency at the same time they are reviewing the report to measure progress toward goals and identify next steps and recommendations for the children and families served.

RECOMMENDATIONS FOR CHILDLINE

1) ChildLine should be exempt from expungement requirements. ChildLine records should be accessible only for Act 33 Reviews and future CPS/GPS investigations. The ChildLine reports will be retained by the child welfare agency for internal access only within the HHS integrated system mentioned below under Legislative Action.

Department response: Expunction occurs under current statutory expungement mandates. The Department acknowledges and supports the current reviews occurring related to proposed changes of expunction laws specifically extending the time in which reports remain on file.

2) ChildLine must always provide all known data on previous county involvement and criminal history to the county receiving any CPS/GPS referral or LEO.

Department response: The Department process is to review all reports that are received for prior CPS/GPS history, including any reports that were LEO only referrals, and transmit that history with the new referral to the county agency. Until the inception of the statewide database in 2015, the Department did not have a record of [redacted] received at the county agencies, therefore, this prior information is not a part of historical information provided.

3) When comparing case note documentation with ChildLine history, dates did not match. Improvement should be made to ensure referral and outcome data congruency between ChildLine and county child welfare agencies.

Department response: ChildLine has a quality assurance unit that reviews the disposition reports received from the counties and regions and requests corrections when discrepancies or missing information is identified. Upgrades

to the CWIS system will include checks and balances related to dates of incidents, reports and submissions that will assist in data congruency.

RECOMMENDATIONS FOR TRAINING

1) Increase child welfare staff training at the "front door" regarding obtaining all information in order to make an informed decision on referral acceptance. Counties should have easily accessible information on family involvement in other child welfare systems to assist in screening decision making.

   Department response: There is current activity occurring in the updating and modification of training for new staff including more experiential learning in which this concept can be reinforced. In addition, when counties receive a report, they are informed of the history of referrals that may have been investigated by other counties. The planned expansion of the database will provide the opportunity for more detailed information on case involvement. The expectation remains that follow up dialogue between counties should occur.

2) Courts continue to need training on family systems as there still exists misunderstanding of past issues' direct impact on current situations.

   Department response: The Department acknowledges the work done through the Administrative Office of Pennsylvania Court's Office of Children and Families in the Courts. Through this office, the development of a Benchbook and supportive resources for dependency court judges has significantly impacted children and families who present before the court. In addition, training for newly appointed judges exists. In both of these resources, areas related to the impact of neglect, trauma and resiliency are addressed.

3) Increased training is needed for mental health facilities, like [redacted] regarding when it is appropriate to involve the county child welfare agency in planning for a child who may appear to have child welfare needs.

   Department response: The Department concurs that cross-system training is critical to assure adequate treatment and discharge planning options are considered.

4) Behavioral health providers, both community and residential, as well as those staff providing therapy as part of child-serving agencies, need training in recognizing and treating victims of sexual abuse, including but not limited to sexual reactive behavior, trauma, and the dynamics in families where sexual abuse occurs.

Department response: The Department concurs with this recommendation for all provider systems to have enhanced trainings on the treatment of the children and families that they serve and that the entities continually assess their training curriculums and content to assure that it meets the needs of their changing populations.

RECOMMENDATIONS FOR STATEWIDE POLICY

1) DHS must assess and establish a policy requiring a response to cases when multiple CPS/GPS referrals are received regardless of whether or not allegations were substantiated.

   Department response: The Department agrees that the area around multiple referrals for a family that are screened out, deemed valid or invalid and/or not accepted for services is a subject that requires further review and analysis toward a determination as to the future policy and guidance needed.

2) A policy needs to be established that requires the state to provide to custodial counties timely information on an investigation and the outcome regarding any allegations of abuse or neglect in a placement setting.

   Department response: Prior to the automated referrals generated through the CWIS, the Regional Offices would provide verbal notice of receipt of an investigation to the county agency involving a child in their custody as well as to the placement entity. They would then send written notification to the county of custody and the placement agency at the outcome of the investigation. The Department acknowledges that the timeframes for notification given the process followed was not immediate. With the inception of CWIS, counties of custody receive immediate notification at the same time of transmission to the regional office as they are identified as secondary recipients of the report. As such, they also receive notification of the disposition upon submission. Verbal notification of receipt and disposition is still provided to placement entities in advance of the written notifications occurring.

   In addition to being secondary recipients of the report, county children and youth agencies respond to the reports not as the investigator of the abuse allegations but as the entity with care and custody of the child. In that role, they assess the safety and well-being needs of the child and make determinations as to the child's living arrangement by initiating court action if a placement change is necessary. The county children and youth agency also arranges for any treatment services that might be identified to address the child's needs.

3) Guidelines from OCYF need to be reinforced regarding "conflicts of interest" for employees of a county or private agency seeking approval to become a foster parent. Agencies should develop policies regarding employees not being utilized as resource parents.

Department response: "Conflicts of interest" relating to county employees serving as foster parents is addressed in Title 55: PA Code, Chapter 3170 Allowable Costs and Procedures for County Children and Youth Social Service Programs. Specifically section 3170.93 (g) address conflict of interest and states: "The appropriate county authority shall not make any contract or agreement with a person, company, or organization in which a member of the county children and youth staff has a financial interest; nor, shall the county authority contract with members in its own staff or their immediate families, except with the clear prior written approval of the regional office."

Title 55: PA Code, Chapter 3680 Administration and operation of a Children and Youth Social Service Agency speaks to the conflict of interest, a related party financial transaction, which would include staff of a private agency to also serve as a foster parent for that same agency. Specifically, section 3680.63 (b) states "No government funds may be used by a private agency in a related party financial transaction without a prior written determination by the Department that the transaction is at a competitive cost or under terms more favorable to the agency." The Department has interpreted an agency staff person also acting as a foster parent for the same agency in which they are employed to be a related party financial transaction, therefore, necessitating a waiver of the regulation.

Agencies must submit for waivers and approvals for staff to serve as foster parents under these regulatory requirements. The submission for approval consideration would include the agency's policies and procedures to address role clarification and function, supervisory oversight, levels of approval, child-specific case decision making and case management. This message has been reinforced with county children and youth agencies as well as private foster care agencies.

RECOMMENDATIONS FOR OVERALL SYSTEMIC CHANGE

1) Implementation of systemic support for child welfare staff who are dealing with a traumatic case is essential in assuring their vicarious trauma is reduced and thus they can continue to effectively deal with this difficult population. This is also a staff retention issue as was seen by the information received during [redacted] case interviews.

   Department response: The Department agrees that continued focus on the well-being of staff must occur as one strategy toward retention. It is important to note that there are currently trainings in place through the Child Welfare Resource Center to assist in maintaining focus on the impact of trauma experienced by our child welfare staff. Module 10: Making Permanent Connections – Outcomes for Professional Development of the current Charting the Course series addresses stressors and self-care. This is continued in the advanced learning sessions of 313: Managing the Impact of

Traumatic Stress on the Child Welfare Professional and 533:Building a Trauma Informed Culture in Child Welfare.

2) Child welfare caseloads should reflect nationally recognized standards of practice as determined by the Casey Foundations and/or the Child Welfare League of America.

   Department response: The Department concurs that the current regulatory citation of 1:30 caseload ratio is outdated. The Department has been drafting updated regulations and proposing staggered reductions in the caseload size that would occur within the three years following promulgation of new regulations. The staggered reductions would lead to a proposed maximum allowable caseload size of 1:10. As with all regulations, county practice and specialty population focus could determine a lower caseload size than what has been set by regulation.

3) Mental health facilities should include child welfare agencies in cases where there are questions about discharge resources and/or safety or risk to a child. [redacted]

   Department response: The Department concurs that behavioral health treatment facilities should be inclusive of all agencies (county behavioral health, managed care organizations, case management) and including children and youth agencies in discharge planning where there are safety threats and risk factors that must be assessed and planned for in advance of the child's release from treatment.

4) Hiring practices for OCYF staff need to be revised to allow for the hiring of applicants with expertise in child welfare including experience in investigating child abuse reports at the county level or in another jurisdiction.

   Department response: As a Commonwealth agency, hiring and minimum education and training requirements are set by the Civil Service Commission. The role of the Human Services Program Representative in OCYF is multi-faceted and the investigation of child abuse reports is one of the primary functions of the position. To focus heavily on child welfare experience in child abuse investigations could limit staff skill sets needed to perform other job functions.

   Staff who do not have county agency experience must attend the Charting the Course modules and become certified as Child Protective Services Workers and then also complete the Supervisory Training Series to receive certification as a Child Protective Service Worker Supervisor. Staff also attend the Sexual Abuse Training Series. New staff also shadow existing

staff on investigations as a means for enhanced learning and skill development.

5) Investigate National Electronic Interstate Compact Enterprise (NEICE) as a potential resource for the Commonwealth of Pennsylvania.

   Department response: The Department concurs and is in the process of development to become enrolled in NEICE.

RECOMMENDATIONS ON LEGAL ISSUES

1) Court involvement should be considered whenever a county is returning children to a home where an allegation of abuse was Indicated, whether or not the perpetrator is remaining in the home. [redacted]

   Department response: The Department agrees that all circumstances and facts of a case, regardless of status determination, should be evaluated and assessed in the context as to whether court action should be initiated for the protection of children involved.

   Please note, for clarification, according to the Department's records, [redacted]

2) The entire system for hearing DHS abuse appeals needs to be evaluated, including establishing mandatory requirements for expertise and training in child welfare for Hearing Officers. Appeals hearings courtrooms need to be child-friendly, including but not limited to, having a separate place for children apart from perpetrators.

   Department response: The Department agrees that reducing trauma to children who must testify in hearings is a matter of importance and will share the recommendations of the county internal report with the Department's liaison for BHA.

3) Mandated reporters should be held accountable if they fail to report suspected child abuse in accordance with the law.

   Department response: The Department agrees and the CPSL addresses that Mandated Reporters who willfully fail to report suspected child abuse can be charged with a crime ranging from a 2nd-degree misdemeanor to a 3rd-

degree felony for the first offense and increase with each subsequent offense. This is also addressed in the PA Crimes Code.

RECOMMENDATIONS REQUIRING LEGISLATIVE ACTION

1) Any legislation passed should have the appropriate fiscal allocation.

   Department response: The process of bill analysis includes an assessment of cost and the inclusion of a fiscal note for consideration of the legislation as the bill moves forward.

2) Expungement regulations and laws need to be re-evaluated to allow for tracking of patterns and review of all history when a new CPS/GPS referral is received. This information is critical in developing a family history of care and safety for a child. The following are recommended as revisions to current expungement requirements:
   - To be able to adequately assess the safety and risk of children, referral and investigation data must be maintained and not expunged for the purpose of county child welfare agency assessment of history when conducting CPS and GPS investigations.
   - Current expungement regulations will apply only to placement on the state registry and for the purposes of child abuse clearances.
   - Confidentiality laws continue to apply to all information released to child welfare agencies on indicated, founded and unfounded reports, both CPS and GPS in nature.

   Department response: The Department acknowledges and supports the current reviews occurring related to proposed changes of expunction laws specifically related to increasing the length of time a report remains on file.

3) Legal barriers to data sharing between child and family serving systems need to be reviewed. Establish the capacity to shared data under the umbrella of the state Department of Health and Human Services. The program must expand upon data maintained in the Master Client Index (MCI). Continue to expand future phases of CWIS.

   Department response: One of the goals of CWIS Phase 2 is to allow county-level case information to be viewed within CWIS by authorized state and county staff. To support our efforts to protect children and staff, counties will have the ability to quickly view case information when a family has moved from one county to another. Currently, county staff do not have historical information which is critical to ensure that they are aware of any previous history that could impact their own safety as well as prior allegations that are critical to making child specific safety decisions.

Department of Human Services Findings:

County Strengths:

Bucks County:

- During the present investigation, there was noted collaboration between the county agency, the courts and law enforcement.
- Timely assessments have been made and relevant services have been implemented for [redacted]
- There is clear documentation in the investigation and structured case notes for ongoing services.
- The [redacted] has been placed in a kinship setting and the county continues to monitor and provide supportive services to assure the child's safety.
- The Act 33 review team conducted extensive interviews with a large number of child welfare professionals and evaluators and reviewed all existing case files and documentation pertaining to the history of the family.

Berks County:

- There was an array of services provided to Grace and her [redacted] family prior to [redacted]

<u>County Weaknesses:</u>

Berks County:

- Grace's [redacted] family was referred for services when the family relocated to Berks County. Part of the referral was related to the [redacted] history as a [redacted] of sexual abuse. It is unclear what immediate actions were taken by the county in assessing and planning for the safety of the girls in this living situation. Despite being provided a number of community interventions; these interventions were not targeted specifically related to the [redacted] history of abusive acts. It was not until one year later that [redacted] had a formal non-offender assessment which resulted in the agency taking protective action for the children's safety.
- Berks County accepted references attesting to the [redacted] family's suitability from those with a vested interest in their approval. In addition, there was concern noted that the family would not be able to appropriately manage a particular type of child which described Grace, yet the family was approved for [redacted]

Lehigh County:

- There was no collaboration or exchange of historical information with the forensic interviewers and Lehigh County during the abuse investigation with the [redacted] which would have resulted in a more thorough evaluation and more appropriate recommendations concerning the safety and well-being of Grace.
- The county did not review the evaluation in the context of the actions of the [redacted] for failing to protect a child entrusted to her care from abuse by the [redacted] The other fact that should have been considered in

context to the evaluation findings was that the [redacted] admitted to having a sexual relationship with the same victim child after the child turned 18. This was a child for whom the [redacted] was in a parental role even after the child became an adult upon her 18th birthday. These key factors were absent from the report and absent from consideration by the county as it related to the safety of Grace and her [redacted]

- Lehigh County did not make alternate placement arrangements for Grace when the informal kinship caregivers were not supportive of the child's needs and trauma during the investigation of sexual abuse of Grace by the [redacted]

Montgomery County:

- Montgomery County received multiple referrals for service for Grace but did not accept the referrals for assessment. The referrals were screened out on the basis of other community responses. These referrals however identified areas of concern related to safety and well-being for the children that at a minimum should have triggered further review and analysis by the county.
    - One referral was for child sexual aggression on another child in the home. The county screened the report out as identifying no abuse allegations and that there were community service providers involved with the family. There was no contact made with the county [redacted] or service providers to gather collateral information toward the screen out decision.
    - When the county received a referral upon Grace's return to Pennsylvania, the basis for the referral included a concern for the lack of a committed caregiver. While the police responded to do a safety check, the need to follow up to the referral extended beyond the immediate safety of the child but rather an overall assessment of continued [redacted] and supervision needs.

<u>Statutory and Regulatory Areas of Non-Compliance by the County Agency:</u>

The failure of the Impact Project to request a waiver for the [redacted] who was an employee, to also act as a [redacted] for the agency is a violation of Chapter 3680.63. A Licensing Inspection Summary (LIS) detailing this violation and seeking a corrective action plan was not sent to the agency as the review conducted in follow up to Grace's death found that this was no longer a practice of the agency. In addition, the requirement for such a waiver was reinforced by DHS with all private foster family care agencies as well as county children and youth agencies following the identification of related facts of this case.

A challenge in reviewing case history that spans for a period of 16 years is identifying and verifying regulatory compliance through review of incomplete records and inability to access and interview all parties who may have

worked with the family throughout the years. In this particular case, there is information which leads to determinations of concerns related to practice, whether minimal regulations were met or not fully implemented.

- Chapter 3490.322 (d) requires that a county agency shall assure the level of activity, in-person contacts with the child, oversight, supervision and services for the child and family are consistent with the level of risk as determined by the county. When the [redacted] of Grace was referred to Berks County from Montgomery County, the children were residing with an adult who was found to have committed child sexual abuse and the referral recommended no contact occur. This referral occurred almost 14 years prior to Grace's death and this fatality review and given expunctions and sealing of records due to [redacted] it is unclear what specific steps were taken in safety assurance for the children. What is known is that the formal evaluation of the parents' ability to protect the children did not occur for one year after the relocation to Berks County and the referral for services, therefore, the level of services were not consistent with the level of risk to the children.
- Chapter 3490.232 requires county children and youth agencies to receive and assess all reports alleging a need for general protective services. Counties have the ability to screen out reports that are received if their review if the information identifies that the report would be a referral to Law Enforcement; that there are no allegations of abuse or neglect; that the referral is a request for a courtesy visit only; or a referral to other community services would best serve the family's need. Montgomery County screened out two referrals regarding Grace Packer based on their assessment that there were no allegations of abuse or neglect and that law enforcement responded. While their assessment of the minimal facts of the referral and screen out action meets regulatory and statutory compliance, the case history of abuse suffered by Grace and inconsistent participation of the [redacted] in cooperation with services were factors that should have also been considered in assessing the level of response that the agency should have taken upon receipt of the referrals.
- Chapter 3130.31 (2)(iv) identifies the responsibilities of the county agency related to cooperation with other providers and agencies to ensure the appropriateness and follow-up of referrals to and from the county agency. Lehigh County referred the [redacted] for forensic interviews upon the report of the sexual abuse of the [redacted] child. The investigation had [redacted] the abusive actions of both the [redacted] and the [redacted] The agency acted upon the evaluator's recommendation for the reunification of the [redacted] with Grace and [redacted] despite the evaluator not fully addressing the responsibility of the [redacted] in failing to protect the [redacted] child from abuse by the [redacted] The agency further did not question the evaluator's lack of addressing the [redacted] acts of engaging in a sexual relationship with the [redacted] child after the child turned 18 while she still was acting in a parental role for

that child. The county appropriately referred the [redacted] for evaluations but accepted the recommendations from a provider without questioning the appropriateness of the report when key areas were not addressed.

Department of Human Services Recommendations:

The Department offers the following recommendations in response to its findings: The Department strongly supports and recommends that counties convene a team at critical case decision-making intervals. At a minimum, this team should consist of key agency staff involved with the family, agency management, and any providers currently involved or those to whom the family will be referred. Where there is behavioral health, medical or education concerns as well as legal implications and potential court involvement, there should representatives from those disciplines. If the regional offices of DHS are involved with the family due to a CPS investigation, the regional office staff should also be a part of the meeting to provide input based on the information obtained during the investigation. In this case, a decision was made to return Grace and [redacted] to the home of the [redacted] despite the [redacted] having [redacted] admitting to having sexual relations with a young woman for whom the [redacted] was in a parenting role and maintaining contact with the [redacted] who had been [redacted] both Grace and another child for whom he had been a [redacted] The decision was reportedly based solely on a forensic evaluation that was accepted without further discussion or question despite the evaluation lacking critical evidence in addressing the [redacted] role in perpetrating sexual abuse.

Current Department regulations identify required information to be shared among counties when one county is making a referral to another county for services upon a family's relocation or identification of residence in another county. The Department recommends a review of implementation policy and practices specific to the level of information sought and provided when one county is referring a family to another county. The Department further recommends specific guidance related to searches for historical case information and involvement in other counties upon receipt of a new referral.

The Department recommends a review of current Screen Out practices within each county to provide guidance related to Screen Out protocols including the level of usage of collateral contacts as well as multiple referrals or prior agency involvements. It is recommended that administrative approvals beyond the Casework Supervisor should be required prior to screening out referrals where there is a history of multiple CPS/GPS referrals having been received regardless of whether or not allegations were substantiated. Additionally, the use of law enforcement or other community providers to assess current well-being in lieu of a

county children and youth agency accepting a referral for investigation should be considered only if the county is seeking an assessment of the physical living environment or condition of the child at that moment. These type of "safety-checks" do not address ongoing safety needs or overall well-being particularly in cases in which there is historical background of prior abuse and/or neglect as well as complex medical or behavioral health needs that would impact the child's ongoing safety.

As previously identified, the Department supports a statutory amendment to extend the length of time unfounded CPS reports and invalid GPS reports remain on file prior to expunction. The availability of historical information and detail is critical to ongoing case assessment as well as overall root cause analysis for case planning and practice. In addition, a review of the mandatory requirement regarding the sealing of files upon final adoption decrees should be reviewed. [redacted] The sealing of past history further limits the identification of prior trauma and present-day treatment needs.

The Department believes that the investigatory process undertaken by the Bucks County and Montgomery County Act 33 Teams in the review of this case is a model that should be shared with the remaining 65 counties to enhance the Child Fatality/Near Fatality review process toward prevention of future incidents of child abuse and child fatality and near-fatality incidents.